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Angina ulcerosa benigna was first described in 1890 by Heryng, who had seen nine cases in nine years. The affection is characterized by the presence of a solitary superficial ulcer or excoriation on the upper part of one of the anterior faucial pillars. The ulcer is oval, measuring about 1 cm. in its long diameter, shallow, with sharp edges, of grey colour, and without inflammatory zone. The surrounding mucous membrane may appear normal, or may be slightly red and swollen. The ulcer heals in from ten to twelve days, and leaves no cicatrix.

Less frequently the ulceration is bilateral, as in one of Heryng's cases, and in two reported by Sendziak: the ulcers in one of the latter were seated on the posterior pillars. In two of Rosenberg's cases, in addition to the ulcer on the anterior faucial pillar, a similar one was present on the tonsil of the same side.

The patient usually complains of painful deglutition, which is out of proportion to the signs of local inflammation. There is slight general disturbance, which as a rule passes off quickly: the pain on swallowing, however, continues until the ulcer begins to heal. The affection is sometimes ushered in with symptoms of an ordinary angina tonsillaris, as in three of Heryng's cases in which the ulcer formed after the fever had subsided.

In none of the cases reported has a connection with syphilis, tuberculosis, or other constitutional disease been

proved to exist. Freudenthal refers to five cases in which an ulcer closely resembling that described by Heryng was associated with rheumatism; in four of these, however, the ulcer was seated on the posterior wall of the pharynx, while in the fifth it was on one of the posterior faucial pillars; the affection, therefore, was probably not identical with angina ulcerosa benigna. M. Schmidt mentions a case in which one of Heryng's benign ulcers appeared in the course of an attack of diphtheria. Sendziak assigns as the cause in one of his patients the abuse of tobacco.

Heryng examined the coating of the ulcers and found that it consisted of dead epithelial cells between which were two forms of streptococci (S. monomorphus and S. variegatus). The subsequent investigations of Lubliner, Masucci, and Sendziak have not fully confirmed the etiological relation of these micro-organisms to the ulcers.

The treatment ordinarily employed in acute inflammation of the fauces suffices.

The following cases of this affection have been observed by the writer:

Case 1.—The patient was a healthy man, about 28 years of age, and was under treatment for nasal obstruction. At one of his visits he complained of sore throat. As he was a professional singer and inclined to pay undue attention to any trivial ailment in this region, and as the only apparent disturbance was slight redness of the fauces no special treatment was recommended. Three days later, however, he returned complaining still more of painful deglutition. An ulcer was now found on the lower half of the left anterior faucial pillar, the neighbouring parts appearing normal. The ulcer was superficial, greyish, circular, and about half a centimetre in diameter. Syphilis at once suggested itself, but after careful investigation it was felt that it could be excluded with certainty. Besides, the pain complained of was much more severe than that accompanying a small mucous patch. The ulcer was painted at intervals with a weak caustic solution; the pain gradually diminished; and the region assumed its normal aspect within a fortnight. The patient has been seen

occasionally since the above attack, but there has been no recurrence.

Case 2.—Mr. L., aged 32, had consulted me on account of the extrusion of cheesy masses from the left tonsil. At one visit, after the tonsil had been reduced and was healed, the stump was painted with a solution of iodine. Four days later he returned complaining that the throat had been sore during the interval, and that on the day following his last visit he had noticed what seemed like a small burn on the left side. On examining his pharynx a superficial, circular, grey ulcer was found which could be covered by the head of a tack, situated on the left anterior faucial pillar close to its edge; the surrounding mucous membrane was normal. A gargle only was prescribed. In about a fortnight after the onset the ulcer disappeared.

Case 3.—Fred ——, aged 15, complained of sore throat of three days' duration. During the previous three years he had had frequent similar attacks.

On examining his throat, he was found to be suffering from acute lacunar tonsillitis. The faucial tonsils were moderately enlarged and presented areas of exudation: a small patch was noted on the left lateral wall of the pharynx: and on the pharyngeal tonsil and lingual tonsil small white points were also observed. Chlorate of potash and iron internally, and an astringent gargle were prescribed.

Four days later he returned. In the interval the throat had been very sore, especially on the left side, but on the preceding day the pain had begun to subside.

Four superficial ulcers were now found on the lower part of the left anterior faucial pillar: two were united at their peripheries and two were isolated. The diameters of these measured 2-3 mm. They were clean, greyish, not elevated, and with no inflammatory areola.

On the following day the ulcers were smaller and more superficial, and there was no pain. Two days later only the faintest traces remained.

Case 4.—Mr. G., aged 31, who was being treated for nasal polypus, complained at one of his visits of sore throat.

Five days previously he had bicycled into the country for the first time. Owing to the unusual exercise, and to hay fever from which he was suffering, he felt out of sorts afterwards. Two days later he had a severe "bilious attack," and the throat became sore. The pain continued throughout the three days preceding his visit, but did not prevent him from attending to business.

On examining his throat two small ulcers were found on each side. These were extraordinarily symmetrical both as to shape and site; the following description therefore applies equally to both sides. One ulcer was seated on the anterior faucial pillar about its middle and ran along its edge. It was 6-7 mm. long, and about 2 mm. in breadth. The other ulcer was oval, measured 2-3 mm. in diameter, and was seated on the tonsil. While the parts were in repose the peripheries of the two ulcers were in contact; on drawing forward the anterior pillar, however, a narrow strip of healthy tissue was found to intervene. Both ulcers were quite superficial, and had light grey clean surfaces: they differed only in shape. There was no inflammatory areola.

Two days later the appearances were almost unchanged.

Eight days after his first visit, the ulcers on the tonsils were merely indicated by minute white specks; those on the anterior faucial pillars presented a slight loss of tissue, which on one side took the form of two tiny notches.

Case 5.—Robert M., aged 23, complained of sore throat of two days' duration. He had had no previous attack. On examining his pharynx the small oval ulcer characteristic of angina ulcerosa benigna was found on the left anterior faucial pillar close to its junction with the tongue.

In the first two cases above reported the ulcer was solitary, and corresponded in appearance and site with Heryng's description of angina ulcerosa benigna; they may therefore be regarded as typical examples of this affection. Doubts may be raised, however, as to the propriety of including Cases 3 and 4 in this group. The former was atypical in its association with acute tonsillitis and in the multiplicity

of ulcers; the latter, in that the ulcers were multiple and bilateral.

The five cases have been grouped together because in all of them the ulcers were identical in appearance—leaving out of account some insignificant variations in size and shape. Further, they were all situated on the anterior faucial pillar, except in Case 4, in which a second ulcer was contiguous on each tonsil. The pathological changes therefore leading to the formation of these ulcers were probably much the same in all four cases.

It is difficult to form an idea of the mode of origin of the solitary ulcer in a typical case of angina ulcerosa benigna, there being usually but little in the history or local appearances to give a clue. On the other hand, when a case presents itself with ulcers on both sides of the fauces which are perfectly symmetrical in shape and arrangement, it is evident that they are due to a constitutional disturbance, which most probably is nervous in character.

In short, we would regard these ulcers as of herpetic origin. Such superficial lesions—they are little more than excoriations—are just what might be expected after rupture of good sized vesicles. Too much importance must not be attached to the fact that a vesicular stage has not been observed. Herpetic vesicles in the mouth are very short lived: and in cases of recurrent herpes which have been watched for long they have been seen only on very rare occasions.

Angina herpetica is quite distinct from the affection under consideration.

The site of these ulcers, on the anterior pillar of the fauces close to its edge, is specially exposed and liable to injury. In Case 2 the ulcer appears to have resulted from painting the region with a moderately strong solution of iodine; it may also be mentioned that this patient was highly neurotic. An acute tonsillitis was the exciting cause in Case 3. In Case 4 the probable cause was a chill in one suffering from hay fever, whose nervous resistance was lowered.

The medical practitioner is not likely to be consulted regarding angina ulcerosa benigna, owing to its comparative

mildness and short duration. Four of the cases above reported were met with accidentally while the patients were under treatment for other ailments.

An acquaintance with the clinical aspect of angina ulcerosa benigna is desirable, owing to the readiness with which it might be mistaken for secondary syphilis. On careful examination, however, the difference between the ulcer and a mucous patch would become apparent, and a consideration of the duration, severity, and concomitant symptoms would lead to a correct diagnosis.

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